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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07482

6361

CERTIFICATE OF DEATH

Reg. Dist. No. 166

Item 9 Film G217 7-15-57 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BAI LAND, MD</u>		LENGTH OF STAY (in this place) <u>7 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL GRANTSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EVANS Nursing Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>EMMA E COBAUGH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 30 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV 1892</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>		11. BIRTHPLACE (State or foreign country) <u>JOHNSTOWN, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOSEPH RIFFLE</u>				14. MOTHER'S MAIDEN NAME <u>LAURA BRUMBAUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-22-5132</u>		17. INFORMANT & ADDRESS <u>Wm COBAUGH, GRANTSVILLE RD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199.9 IMMEDIATE CAUSE (A) <u>Carcinomatous</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malnutrition</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/18</u> , 19 <u>57</u> , to <u>6/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/29</u> , 19 <u>57</u> , and that death occurred at <u>3:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>25 Cedar St</u>		DATE SIGNED <u>7/1/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/2/57</u>		NAME OF CEMETERY OR CREMATORY <u>100 F</u>		LOCATION (City, town, or county) (State) <u>SALISBURY, SOMERSET Co PA</u>	
24. REG'D BY REGISTRAR <u>7/2/57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Grantsville Md</u>	

CERTIFICATE OF DEATH

Reg. No. 111

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Print or write full name)

9. Place of death (City, State, Country)

10. Signature of physician (Print or write full name)

11. Signature of registrar (Print or write full name)

12. Signature of informant (Print or write full name)

13. Signature of witness (Print or write full name)

14. Signature of witness (Print or write full name)

15. Signature of witness (Print or write full name)

16. Signature of witness (Print or write full name)

17. Signature of witness (Print or write full name)

18. Signature of witness (Print or write full name)

19. Signature of witness (Print or write full name)

20. Signature of witness (Print or write full name)

21. Signature of witness (Print or write full name)

22. Signature of witness (Print or write full name)

23. Signature of witness (Print or write full name)

24. Signature of witness (Print or write full name)

25. Signature of witness (Print or write full name)

26. Signature of witness (Print or write full name)

27. Signature of witness (Print or write full name)

28. Signature of witness (Print or write full name)

29. Signature of witness (Print or write full name)

30. Signature of witness (Print or write full name)

31. Signature of witness (Print or write full name)

32. Signature of witness (Print or write full name)

33. Signature of witness (Print or write full name)

BUREAU V. S.

JUL 11 1957

RECEIVED

200120197211

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6362

CERTIFICATE OF DEATH

06351

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Accident</u>		<u>LIFE</u>		TOWN <u>Accident</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Frederick Smith Friend</u>				<u>June 12, 1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>M</u>	<u>Nov. 1, 1875</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>OWN FARM</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>David H. Friend</u>				<u>Mary Jane Gary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Claude Friend, Accident, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>422.2 IMMEDIATE CAUSE (A) <u>Myocarditis, Chronic</u></u>				INTERVAL BETWEEN ONSET AND DEATH			
<u>ANTECEDENT CAUSE(S) DUE TO</u>				<u>2 1/2 years</u>			
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>							
<u>STATING UNDERLYING CAUSE LAST, DUE TO</u>							
<u>(C)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January 5, 1955</u> , to <u>June 11, 1957</u> , that I last saw the deceased alive on <u>June 11, 1957</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Milton Jeffer, m.d.</u>		<u>M.D. Friendsville, Md.</u>		<u>June 15, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 16, 1957</u>		<u>St. Pauls Cemetery</u>		<u>Accident, Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JUN 19 57</u>		<u>W. H. Schuch</u>		<u>Claude J. Newman</u>		<u>Grantsville, Md.</u>	

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6363 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 166

06352

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nr. Oakland, (RURAL)</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ RURAL Nr. Oakland, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Orval Harrison Friend</u>				4. DATE OF DEATH Month Day Year <u>6 7 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-27</u>	
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>McHenry, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alvin Friend</u>				14. MOTHER'S MAIDEN NAME <u>Thresda Ella Teets</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1-18-48 to 7-31-50</u>				16. SOCIAL SECURITY NO. <u>216-22-6413</u>			
17. INFORMANT <u>Delores Whitacre Friend, Rt. 1 Oak., Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous Subarachnoid Hemorrhage</u> 330X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Instant.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, JR., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6.9.57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 11-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOYES RUN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR OAKLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u>				ADDRESS <u>OAKLAND MD</u>		24a. REC'D BY REGISTRAR <u>6/11/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John A. Brown</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 14 1957

RECEIVED

6364

CERTIFICATE OF DEATH

Reg. Dist. No. 06353

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS GREEN ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last RENE CAROL JONES				4. DATE OF DEATH Month Day Year JUNE 20 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB.-26-1956	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OAKLAND MD		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME HOWARD JONES		14. MOTHER'S MAIDEN NAME MARTHA BECKMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HOWARD JONES		Address OAKLAND MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) neuroblastoma 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 70 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 Feb , 19 56 , to 20 June , 19 57 , that I last saw the deceased alive on 19 June , 19 57 , and that death occurred at 6:57 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 22 June '57							
ACTUAL SIGNATURE A E Mance M.D.				PHYSICIAN'S NAME (Type) A E MANCE MD OAKLAND, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE-23-1957		22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden ADDRESS OAKLAND MD				24a. REC'D BY REGISTRAR 6/23/57 DATE		24b. REGISTRAR'S SIGNATURE Julius C. Poy...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

JUN 27 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06354

6365 CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garett</u>		MARYLAND		STATE <u>W Va,</u>		COUNTY <u>Preston</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Oakland Md,</u>		LENGTH OF STAY (in this place) <u>1 Year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Terra Alta W Va.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Weeks Nursing Home,</u>				STREET ADDRESS (If rural give location) <u>85x-3</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Charles Kelly,</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 19 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 25 1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Preston County W Va,</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Smith E Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Mary Martha Browning,</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>234 - 26-5945a</u>		17. INFORMANT & ADDRESS <u>Mrs M, O, Miller,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u>						<u>15 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>450.0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 1950</u> to <u>June 19, 1957</u> that I last saw the deceased alive on <u>June 17, 1957</u> and that death occurred at <u>10:10 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>M. Vance Clark Harley M.D.</u>		ADDRESS (Street, city, town, state) <u>Terra Alta W. Va</u>		DATE SIGNED <u>6-19-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>June 22/57</u>	NAME OF CEMETERY OR CREMATORY <u>Terra Alta, Cemetery,</u>		LOCATION (City, town, or county) (State) <u>Terra Alta, W Va,</u>			
24. REC'D BY REGISTRAR <u>6/22/57</u>	REGISTRAR'S SIGNATURE <u>James C. Rooper</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Reighton</u>		ADDRESS <u>Oakland Md</u>		

NOTIFICATION

1. This form is to be filled out by the person who has knowledge of the death and is to be submitted to the Bureau of Health Statistics, State of Maryland, Baltimore, Maryland, as soon as possible after the death.

2. The information furnished on this form is for the purpose of compiling statistics and is not to be used for any other purpose.

3. The information furnished on this form is to be kept confidential and is not to be disclosed to any person except as may be required by law.

4. The information furnished on this form is to be kept confidential and is not to be disclosed to any person except as may be required by law.

5. The information furnished on this form is to be kept confidential and is not to be disclosed to any person except as may be required by law.

6. The information furnished on this form is to be kept confidential and is not to be disclosed to any person except as may be required by law.

7. The information furnished on this form is to be kept confidential and is not to be disclosed to any person except as may be required by law.

8. The information furnished on this form is to be kept confidential and is not to be disclosed to any person except as may be required by law.

9. The information furnished on this form is to be kept confidential and is not to be disclosed to any person except as may be required by law.

10. The information furnished on this form is to be kept confidential and is not to be disclosed to any person except as may be required by law.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF STATE

21. SIGNATURE OF COUNTY

22. SIGNATURE OF CITY

23. SIGNATURE OF TOWNSHIP

24. SIGNATURE OF WARD

25. SIGNATURE OF BLOCK

26. SIGNATURE OF HOUSE

27. SIGNATURE OF ROOM

28. SIGNATURE OF BED

29. SIGNATURE OF CHAIR

30. SIGNATURE OF TABLE

31. SIGNATURE OF CUPBOARD

32. SIGNATURE OF DRAWER

33. SIGNATURE OF DOOR

34. SIGNATURE OF WINDOW

35. SIGNATURE OF FLOOR

36. SIGNATURE OF CEILING

37. SIGNATURE OF WALL

38. SIGNATURE OF ROOF

39. SIGNATURE OF GROUND

40. SIGNATURE OF AIR

41. SIGNATURE OF WATER

42. SIGNATURE OF FIRE

43. SIGNATURE OF LIGHT

44. SIGNATURE OF SOUND

45. SIGNATURE OF SMELL

46. SIGNATURE OF TASTE

47. SIGNATURE OF TOUCH

48. SIGNATURE OF FEEL

49. SIGNATURE OF THOUGHT

50. SIGNATURE OF EMOTION

51. SIGNATURE OF BEHAVIOR

52. SIGNATURE OF CHARACTER

53. SIGNATURE OF REPUTATION

54. SIGNATURE OF HISTORY

55. SIGNATURE OF FUTURE

56. SIGNATURE OF DESTINY

57. SIGNATURE OF FATE

58. SIGNATURE OF LUCK

59. SIGNATURE OF CHANCE

60. SIGNATURE OF PROVIDENCE

Handwritten signature

BUREAU V. 5

JUN 27 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06355

6366

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL FROSTBURG</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL FROSTBURG</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>ALBERT LEUORIAL MINNICK</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 2 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH 16 1897</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>		11. BIRTHPLACE (State or foreign country) <u>GARRETT Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT MINNICK</u>				14. MOTHER'S MAIDEN NAME <u>MARY McKENTIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-16-2547</u>		17. INFORMANT & ADDRESS <u>JAMES MINNICK, FROSTBURG MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Cardiovascular Renal Dis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>442X</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 2</u> , 19 <u>55</u> , to <u>June 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 2</u> , 19 <u>57</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis</u>		M.D.		ADDRESS (Street, city, town, state) <u>2 Broadway, Frostburg MD</u>		DATE SIGNED <u>6/5/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6/5/57</u>		NAME OF CEMETERY OR CREMATORY <u>McKENZIE</u>		LOCATION (City, town, or county) (State) <u>RURAL FROSTBURG, GARRETT Co MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Donald Newman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Newman</u>		ADDRESS <u>Frostburg Md</u>	
DATE <u>JUN 7 '57</u>							


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JUN 2 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G217 7-1-57 et

6367

CERTIFICATE OF DEATH

Reg. Dist. No.

06356
166

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN lb <u>9 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xo Crellin, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Amos</u>		First <u>Walter</u>		Middle <u>Moats</u>		Last	
4. DATE OF DEATH <u>June 22 19 57</u>		Month <u>June</u>		Day <u>22</u>		Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-79</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired miner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Moats</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lipscomb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>216-14-1774</u>		17. INFORMANT <u>Russell Moats, Crellin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>241X Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Branchial Asthma</u> (c) <u>malnutrition - severe protein</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition - severe protein</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>57</u> , and that death occurred at <u>10:47</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. J. Bannister</u> M.D.				ADDRESS (Street, city or town, state) <u>Dallan Saw</u>		DATE SIGNED <u>6/22/57</u>	
PHYSICIAN'S NAME (Type) <u>E. J. Bannister</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE-24-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>AURORA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>AURORA W. VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u>				ADDRESS <u>OAKLAND MD.</u>		24a. RECEIVED BY REGISTRAR DATE <u>6/24/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John C. Rowan</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06357

6368

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 1 STAR ROUTE	
3. NAME OF DECEASED (Type or print) First PAUL Middle SHAW Last PARKER, SR		4. DATE OF DEATH Month JUNE Day 6 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/86
9. AGE (In years less birthday) yrs. 71		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY BAPTIST CHURCH	
11. BIRTHPLACE (State or foreign country) FLORENCE, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME CHARLES D. PARKER		14. MOTHER'S MAIDEN NAME ALVERDA M. SHAW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-36-8 680	
17. INFORMANT Address Pauline E. Parker Star Route, Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 456X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Fibrosis (c) Calcific aortitis		INTERVAL BETWEEN ONSET AND DEATH 38 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/20/53, to 6/6/57, that I last saw the deceased alive on 6/6/57, and that death occurred at 9:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Oakland Md 6 June 57	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal - Burial 16/9/1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Vincent Baptist Church Cem.		22d. LOCATION (City, town, or county) (State) Chester Springs, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herbert C. Leighton Oakland, Md.		24a. REC'D BY REGISTRAR DATE 6/9/57	
24b. REGISTRAR'S SIGNATURE Julian C. Roway			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6369

CERTIFICATE OF DEATH

Reg. Dist. No.

06358

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 6 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McHenry X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Ellsworth Last Sims				4. DATE OF DEATH Month June Day 6 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1875	
9. AGE (In years last birthday) 81 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer Saw Mill		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Sims				14. MOTHER'S MAIDEN NAME Eliza Tasker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-07 -2628		17. INFORMANT Randall Sims		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral, Unclonic Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Senile						INTERVAL BETWEEN ONSET AND DEATH 3 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1957 , to June 6, 1957 , that I last saw the deceased alive on June 5, 1957 , and that death occurred at 11:15A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED June 6, 1957							
ACTUAL SIGNATURE James H. Feaster				M.D. 5824 51- Oakland Md 6-7-57			
PHYSICIAN'S NAME (Type) James H. Feaster, M.D.				Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1957		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery		22d. LOCATION (City, town, or county) (State) Garrett Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Reighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR 6/8/57	
24b. REGISTRAR'S SIGNATURE Julia G. Gowan							

JUN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 180359

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEER PARK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>ROUTE #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>EDGAR</u> Last <u>STRAWSER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1957</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12.27.63</u>		
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>EGLON, W.VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH N. STRAWSER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA PARKS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-6751</u>		17. INFORMANT Address <u>MRS. NELDA M. STRAWSER, DEER PARK, MD.,</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>(History of old rheumatic heart disease</u> (a), stating the underlying cause lost. DUE TO <u>a number of years ago.)</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>416x</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO INJURY</u>					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>				DATE SIGNED <u>6-1-57</u>				
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, JR., M. D.,</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTING				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eglon Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eglon, Preston Co. W. Va.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighdon</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR <u>6/4/57</u>		
				24b. REGISTRAR'S SIGNATURE <u>John H. Noway</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see page 4 should be written the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUN 6 1957

RECEIVED

RECEIVED

6/11/57
BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6371

CERTIFICATE OF DEATH

Reg. Dist. No. 166

06360

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle BRYAN Last THAYER		4. DATE OF DEATH Month JUNE Day 3 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SURVEYOR'S HELPER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN THAYER		14. MOTHER'S MAIDEN NAME VIRGINIA WELCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-1047	
17. INFORMANT MRS. EARL THAYER		Address - STAR ROUTE -OAKLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) Cardio-Renal DUE TO Cause			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442 X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUN 3rd , 19 57 , to JUNE 3 , 19 57 , that I last saw the deceased alive on JUNE 3rd , 19 57 , and that death occurred at 5:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D. 58 2nd St. Oakland, Md.		DATE SIGNED 6.3.57	
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.		58 2nd STREET OAKLAND, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/6/57	22c. NAME OF CEMETERY OR CREMATORY Thayerville	22d. LOCATION (City, town, or county) (State) near Oakland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR 6/6/57		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. S.

JUN 2 1957

RECEIVED